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Cover Photographs

Left: From Mitral Valve Hemodynamics After Repair of Acute Posterior Leaflet Prolapse: Quadrangular Resection Versus Triangular Resection Versus Neochordoplasty. The schematic depicts 3 types of surgical techniques that are commonly used to correct acute posterior leaflet prolapse due to chordal rupture. Left, Neochordoplasty: top, the procedure to place ePTFE neochordae through the papillary muscle tips into the prolapsing leaflet segment; bottom, a physiologically competent valve after surgical neochordoplasty. Middle, triangular resection: top, the dotted line depicts the leaflet region that is resected from the prolapsing segment; bottom, surgically reconstructed valve leaflet with excellent valve competence. Right, quadrangular resection: top, the dotted line depicts the region of leaflet resection and annular compression; bottom, surgical reconstruction of the posterior mitral leaflet by approximating the free edges and outwardly compressing the annulus.

Center: From Initial Results With Minimally Invasive Repair of Pectus Carinatum. As the bar reaches the hole on the lateral chest wall on the left side, its end is pulled out to the outer surface of the ribs. The figure shows the final position of the bar.

Right: From Evaluation of a New Hybrid Technique for Closure of Muscular Ventricular Septal Defects in a Long-Term Setting. The figure shows on the left the patch delivery system with the polyethylene tube covered nitinol frame (A–C). The polyester patch is sutured with a nitinol twine to the tube. A stapler system applies nitinol anchors through the patch into the septum (D–E). On the right is symbolized on a piece of ventricular septum the way of application inside the heart. The patch is placed through the aorta (F). G and H, Fixation of a mini nitinol anchor on the muscular septum with the custom-designed stapler (G–I). Releasing of the sutures detaches the nitinol frame from the patch (J). The patch remains with the mini nitinol anchors in the muscular septum (K).